

<b>Case Number:</b>	CM14-0033210		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	05/20/2010
<b>Decision Date:</b>	09/08/2014	<b>UR Denial Date:</b>	02/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/17/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 53-year-old female who has submitted a claim for lumbar spine strain with disc lesion of the lumbar spine with radiculitis/radiculopathy; associated with an industrial injury date of 05/20/2010. Medical records from 2013 to 2014 were reviewed and showed that patient complained of lower back pain and spasms radiating down into her right gluteal area and up into her right shoulder blade. She experienced an increase in spasms and pain in her lower back since a recent flare up on 12/20/2013. Physical examination showed +3 tenderness and spasms in the lumbar paraspinals. There was guarded range of motion in all ranges. There was tenderness at the facets. Straight leg raise test was positive on the right at 60 degrees. There was hypoesthesia at L4 through S1 dermatomes on the right. Kemp's test was positive. MRI of the lumbar spine, dated 02/08/2011, showed bilateral neuroforaminal narrowing, left more than right, at the levels of L4-L5 and L5-S1. Treatment to date has included medications. Utilization review, dated 02/19/2014, modified the request for LUMBAR EPIDURAL STERIODAL BASED THERAPEUTIC PROCEDURE WITH PROCEDURAL MODIFICATIONS AS INDICATED AT L4-L5 AND L5-S1 (TO INCLUDE OFFICE VISIT, DECOMPRESSION, ESI, CT MYELOGRAM) to RIGHT EPIDURAL STEROID INJECTION AT L4-L5 AND L5-S1, AND SUBSEQUENT OFFICE VISIT because there was no clear medical necessity for decompression and CT myelogram as part of the epidural injections.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Lumbar Epidural Steriodal based therapeutic procedure with procedural modifications as indicated at L4-L5 and L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300,Chronic Pain Treatment Guidelines Epidural Steriod injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation ODG for low Back regarding epidural steriod injections (ESIs), therapeutic.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTION Page(s): 46.

**Decision rationale:** As stated on page 46 of the MTUS Chronic Pain Guidelines, epidural steroid injections (ESI) are recommended as an option for treatment of radicular pain. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Also, the patient must be initially unresponsive to conservative treatment. In this case, the patient complains of low back pain with radicular symptoms. Physical examination showed hypoesthesia over the L4 through S1 dermatomes, and positive Kemp's and straight leg raise tests. However, the medical records submitted for review failed to show evidence of failed trial of conservative treatment (including physical therapy). Moreover, an MRI of the lumbar spine, dated 02/08/2011, failed to show significant neuroforaminal narrowing or frank nerve root compromise. Furthermore, there was no discussion regarding the need for procedural modifications as indicated in the present request. The criteria for ESI have not been met. Therefore, the request is not medically necessary.

**Decompression: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** According to pages 305-307 of the ACOEM Guidelines, lumbar surgical intervention is recommended for patients who have severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short- and long-term from surgical repair; and failure of conservative treatment. In this case, the patient complains of low back pain with radicular symptoms. Physical examination showed hypoesthesia over the L4 through S1 dermatomes, and positive Kemp's and straight leg raise tests. However, an MRI of the lumbar spine, dated 10/08/2011, failed to show significant neural foraminal narrowing or nerve root compromise. Moreover, the medical records submitted for review failed to show evidence of failed trial of conservative treatment (including physical therapy). Lastly, the present request as submitted failed to specify the level of the intended procedure. Therefore, the request for decompression is not medically necessary.

## **Epidural Steroid Injection (ESI): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines for Low Back regarding epidural steroid injections (ESIs), therapeutic.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTION Page(s): 46.

**Decision rationale:** As stated on page 46 of the MTUS Chronic Pain Guidelines, epidural steroid injections (ESI) are recommended as an option for treatment of radicular pain. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Also, the patient must be initially unresponsive to conservative treatment. In this case, the patient complains of low back pain with radicular symptoms. Physical examination showed a hypoesthesia over the L4 through S1 dermatomes, and positive Kemp's and straight leg raise tests. However, the medical records submitted for review failed to show evidence of failed trial of conservative treatment (including physical therapy). Moreover, MRI of the lumbar spine, dated 02/08/2011, failed to show significant neuroforaminal narrowing or frank nerve root compromise. Lastly, the present request as submitted failed to indicate the level of the intended procedure. The criteria for ESI have not been met. Therefore, the request is not medically necessary.

## **Computed Tomography Myelogram: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Myelography.

**Decision rationale:** The ODG states that CT Myelography is recommended when an MRI imaging cannot be performed or in addition to an MRI. Invasive evaluation by means of computed tomography myelography may be supplemental when visualization of neural structures is required for surgical planning. Myelography and CT Myelography have largely been superseded by the development of high resolution CT and magnetic resonance imaging (MRI). In this case, the patient has been complaining of low back pain with radicular symptoms. However, there was no evidence that an MRI of the lumbar spine, which is the preferred study, cannot be performed. Moreover, there was no discussion regarding planned surgical intervention. Lastly, the present request as submitted failed to specify the targeted area of the intended procedure. The guideline criteria have not been met. As such, the request is not medically necessary and appropriate.